berri eyecare
WE'RE FOCUSED ON YOUR VISION!

WELCOME TO OUR OFFICE

Today's Date_____

Last_____ First_____ MI____

Street_____

City_____ State ____ Zip _____

Home Ph_____ Work Ph_____

Cell Ph_____ Birthdate_____

Gender M F Email_____

Status: Single Married Other

Employed Not Employed Retired Full-time Student

Employer or School_____

Occupation or Grade_____

Whom may we thank for referring you to our office?

_____

Please list other members of your household we have seen.

_____

Emergency Contact_____

Phone_____ Relationship to Patient_____

Reason for today's visit _____

Insurance

Vision Insurance Company_____

Subscriber Name_____

Subscriber SS#_____ Employer_____

Subscriber Birthdate_____ Relationship to Patient_____

Medical Insurance Company_____

Subscriber Name_____

Subscriber SS#_____ Employer_____

Subscriber Birthdate_____ Relationship to Patient_____

Do you participate in a Flex Spending Plan? Yes No

Family Health & Eye History

Please list any **FAMILY MEMBERS** who have the following.

Glaucoma_____

Macular Degeneration_____

Blindness_____

Other Eye Problem_____

Diabetes_____

Heart Disease_____

High Blood Pressure_____

Stroke_____

High Cholesterol_____

Other significant family history_____

Patient Health History

Family Doctor_____

Date of last check-up/physical_____

Medications_____

_____

Allergies_____

Surgeries_____

_____

Have **YOU** had or been treated for any of the following problems?

___Allergies/Sinus Problems
___High blood Pressure
___Cholesterol
___Heart Disease
___Diabetes
___Thyroid Disease
___Other Endocrine Disorder
___Acid Reflux
___Irritable Bowel
___Other GI Problem
___Anemia
___Other Blood Disorder
___HIV/AIDS
___Other Immunologic Disorder
___Other Problem_____
___Rosacea
___Other Skin Disorder
___Rheumatoid Arthritis
___Other Arthritis
___Migraines
___Multiple Sclerosis
___Other Neurological Disorder
___Depression
___Anxiety
___Other Psychiatric Disorder
___Asthma
___Sleep Apnea
___Other Respiratory Disorder
___Cancer

Tobacco Use?
None Smoke: < 1 pack/day 1-2 packs/day 3+ packs/day

Alcohol Use?
None Occasional Use 1-2 drinks/day 3+ drinks/day

Narcotic/Drug Use?
None Recreational Use Drug Dependence

Women Only
Are you Pregnant/Breastfeeding? Y N Are you on Birth Control? Y N

Patient Eye History

Last Eye Exam_____ Where_____

Have **YOU** had or been treated for any of the following problems?

___Cataracts
___Corneal Abrasion
___Eye Infection
___Eye Injury
___Glaucoma
___Iritis/Uveitis
___Ocular Allergies
___Lazy Eye
___Macular Degeneration
___Retinal Detachment
___Loss of Vision
___Other Vision Disorder

List any eye surgeries_____

Are **YOU** experiencing any of the following problems?

___Blurred Vision
___Double Vision
___Frequent Headaches
___Eye Strain
___Eye Pain
___Light Sensitivity
___Flashes of Light
___Spots in Vision
___Poor Night Vision
___Trouble with Glare
___Trouble Reading or Seeing Computer
___Dry or Gritty Eyes
___Watery Eyes
___Itchy Eyes
___Burning Eyes
___Flucuating Vision
___Vision Loss
___Other Vision Problem

Do you... ? (check if answer is YES)

___Wear glasses?
___Want thinner lenses?
___Use a computer?
___Play sports?
___Have children?
___Spend a lot of time outdoors?
___Have current back-up glasses?
___Have sunglasses?
___Want LASIK information?
___Want to "test-drive" the latest contact lenses?

Contact Lens Wearers Only
Are you happy with current lens comfort? Y N Current lens vision? Y N

Financial Responsibility

I agree to pay in full at the time of service, all fees due to Berri Eyecare, including co-pays, co-insurance and fees not covered by insurance. I also understand that should Berri Eyecare file for payment from the patient's insurance company, and those fees are not paid for any reason by the patient's insurance company, I am fully responsible for those fees.

Signature X_____

Date_____ Relationship to Patient_____

Insurance Authorization

Our Insurance Policy: Berri Eyecare will file insurance claims only with insurance companies with whom we have an active contract. It is your responsibility to know the patient's insurance policy coverage and limits. We may estimate what the insurance company will pay, but the insurance company makes the final determination of payment. You will be responsible in full for any portion not covered or not paid in a timely manner by the patient's insurance company. If you feel the patient's insurance company has wrongly denied the patient's claim, you will need to contact the insurance company. We will be happy to assist if we can.

Authorization

I hereby authorize Berri Eyecare and its doctors to release to the patient's insurance company any information from the patient's examination and/or treatment necessary to process any insurance claim.

I authorize payment of benefits to Berri Eyecare if and when assignment has been accepted.

Signature X_____

Date_____ Relationship to Patient_____

Privacy Policy Acknowledgement

I acknowledge I have received or have been offered a copy of the "Notice of Privacy Practices" from Berri Eyecare.

Signature X_____

Date_____ Relationship to Patient_____

Information Sharing

We value your right to privacy. There may be times when it is to your benefit for us to share information with others. This information may include but is not limited to: vision results, test results, prescriptions, contact lens information, diagnosis, treatment, and prognosis.

May we have your permission to share any and all information we have gathered during your eye examination with your **other healthcare providers**?

Please circle one. YES NO

Sometimes it is helpful if we may discuss your information with a spouse, family member, care giver or other person. Is there anyone (other than one of your healthcare providers) with whom we may share your information?

Please circle one. YES NO

In the space below, please clearly PRINT the names of anyone we may share any or all information we have gathered during your eye examination.

Name_____

Relationship to Patient_____

Name_____

Relationship to Patient_____

Name_____

Relationship to Patient_____

Name_____

Relationship to Patient_____

Name_____

Relationship to Patient_____

Name_____

Relationship to Patient_____

Signature X_____

Date_____ Relationship to Patient_____